Task Force on the Quality of Services for Individuals with Developmental Disabilities
Bernard Simons, Deputy Secretary, DDA, Co-chair
Dr. Patricia Nay, Executive Director, OHCQ, Co-chair
December 3, 2014

Location of Meeting:
Spring Grove Hospital Center, Bland Bryant Building
55 Wade Avenue
Catonsville, Maryland 21228

Attendees: Bernard Simons, DDA; Dr. Patricia Nay, OHCQ; Janet Furman, DDA; Valerie Roddy, DDA; Margie Heald, OHCQ; Allison Orlina, OHCQ; Darlene Ham, DHR; Margaret Holmes, Legal Aid; Jason Noel, Mortality Committee; Dr. Christopher Smith, Kennedy Krieger, MCDD; Sharon Krevor-Weisbaum, Brown Gold; Nancy Pineles, MDLC; Christine Marchand, ARC of Maryland; Laura Howell, MACS; Susan Panek, Medicaid; Kathleen Durkin, ARC of Baltimore; Brian Cox, DD Council; Patricia Arriaza, GOC; Shelley Tinney, MARFY

Guests: Nicole Smith, DDA
See sign-in for additional guests

Welcome and Introduction: Bernie Simons opened the meeting at 10:02 a.m. and asked the task force members, agency staff, and visitors to introduce themselves.

Purpose of Task Force: The Task Force has been charged with continuing to explore improvements in the oversight of DDA licensed services. Given the time limitations to develop recommendations, the task force is focusing on providers serving children.

Task Force Minutes: Panel members were sent via email the minutes from the November 19, 2014 meeting for review. Bernie Simons asked the panel if they had any edits or corrections. There were no requests for changes. The minutes were unanimously approved.

Children's Legislative Report: Tricia Nay reported that the Department of Health and Mental Hygiene's report, Review of Services for Medically Fragile Foster Care Youth, was based on a review of four facilities that provide services to these individuals. The purpose of the review was to identify areas for improved oversight. As part of the review, this task force was convened to further explore the quality oversight of services for individuals with developmental disabilities. The report included five recommendations:

1. OHCQ recommends clarification and documentation of the roles and responsibilities within and between agencies that provide oversight to these providers. Projected date: January 2015.
2. Each government agency should maximize data point collection for each oversight activity it carries out. An analysis of that data should be shared with other agencies, as appropriate, through formal processes. Projected date: June 2015.

3. The initial licensure process for programs for medically fragile children should be reviewed and revised to ensure that applicants have a sustainable business model. Projected date: February 2015.
4. As the lead on investigations of complaints and self-reported incidents, OHCQ should develop formal processes to ensure that coordination with other agencies occurs in a timely and consistent way. Projected date: January 2015.
5. The children's unit at OHCQ should receive an additional position to serve as a coordinator to implement these recommendations and ensure oversight over the medically fragile children's homes. Projected date: December 2014.

The task force's discussion included the following topics:

- The most frequently cited deficiencies in the children programs from January 2011 to August 2014 are described on page five the children's legislative report. The most frequent deficiency cited was the lack of documentation for required staff training.
- The first three recommendations in the children's report also apply to DDA.
- The Department, DHR, and others are developing a one-page chart that shows the roles of the various agencies and stakeholders. The chart will be posted on OHCQ's website for the DD task force.
- Data collection and analysis was identified as an important area for improvement. Dr. Smith, Kennedy Krieger Institute, offered his assistance to the Department to enhance data management.
- There are multiple opportunities to improve the licensing process to make it both more efficient and effective.
- There are concerns about the providers' training, recruitment, and retention of staff.
- OHCQ clarified that the use of electronic documentation with respect to required training, such as CPR, was consistent with the regulations. Margie Heald stated that OHCQ encourages providers to use electronic records.
- Currently, the service delivery system encompasses nursing protocols for homes that are handling medically fragile children. The Governor's Office for Children (GOC) is creating a process on rate setting bundles in which to maximize federal funding. The IRC is looking at the rates and the regulations. There was discussion about individualization of rates and blending the rates between DDA and REM systems.
- In regards to medically fragile children, there are challenges with nursing education and training. There are opportunities for learning and skills enhancement in nursing programs, on-the-job training, and the use of selected providers as training sites for nurses to gain hands-on experience.
- In regards to medically fragile children, there are complex medical and psychosocial needs. Consideration was given to providers using one physician or a medical director rather than multiple physicians with varying levels of experience with this population. This was balanced with the right of an individual to choose their own physician.
- If a medical director was required in an administrative role, there are concerns about the availability of interested physicians in certain geographic areas and the need to increase

funding to cover this cost. In addition to physicians, there are other professionals who are very important in providing and coordinating the care of these children.

- If the medically fragile children were placed in foster care homes and integrated more fully into the community, then there are considerations related to quality assurance, delivery of services, oversight, recruitment of families, and respite for families.
- The lack of a published rate for children transitioning to adult providers and coordination with children's hospitals was identified as a concern.
- According to one provider, payments are rendered monthly and are on time. If the system of delivery with respect to payments changes, then payments would be quarterly. This may hinder services to clients and keeping staff on payroll. Another concern is that the 50% federal match could change.
- Additional statistics about the medically fragile children were requested. DHR will get additional information about the number of medically fragile children currently in foster care homes.

Suggestions for interventions or recommendations included:

- An accreditation requirement be added to the licensing process for providers that serve medically fragile children.
- A Memorandum of Understanding (MOU) between DDA, OHCQ, DHR, and Medicaid should be established to address the roles, responsibilities, and sharing of information.
- For quality assurance, monitoring responsibilities should be geared toward the REM coordinators who oversee medically fragile children.
- The service delivery system should be under DDA and Medicaid rather than DHR.
- Currently children's homes are funded under DHR Foster Care Unit, but they should be moved under the DDA system.
- A child should remain connected to their family and integrated in the community while receiving services.
- DDA needs to strengthen the process of creating and implementing stronger regulations on clients' individual plans.

Next steps: The Department will compile the potential recommendations for further review and discussion by the task force.

The meeting ended at 11:54 a.m. The task force will meet again on January 7, 2015, 10:00 a.m. – 12:00 noon.